

File

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: HEALTH CARE FINANCING ADMINISTRATION	1. TRANSMITTAL NUMBER: <u>01</u> — <u>0</u> <u>0</u> <u>7</u>	2. STATE: Rhode Island
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE 1/01/01	

5. TYPE OF PLAN MATERIAL (Check One):

☐ NEW STATE PLAN
 ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN
 ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION: Section 1902 (a) (55) of the Social Security Act	7. FEDERAL BUDGET IMPACT: a. FFY <u>2001</u> \$ <u>252,000</u> b. FFY <u>2002</u> \$ <u>259,560</u>
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Section 2.1, page 11a	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): New


10. SUBJECT OF AMENDMENT:

Applications/Outstationing

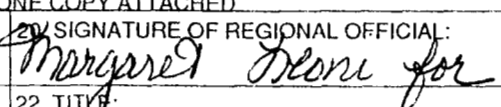
11. GOVERNOR'S REVIEW (Check One):

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

☒ OTHER, AS SPECIFIED:
See attached letter.

12. SIGNATURE OF STATE AGENCY OFFICIAL: 	16. RETURN TO: Dorothy Karolyshyn Department of Human Services 600 New London Avenue Cranston, RI 02920
13. TYPED NAME: Christine C. Ferguson	
14. TITLE: Director	
15. DATE SUBMITTED: 3/15/01	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 3-20-01	18. DATE APPROVED: 4-4-01
19. EFFECTIVE DATE OF APPROVED MATERIAL: 01-01-01	
20. TYPED NAME: Ronald Preston	21. SIGNATURE OF REGIONAL OFFICIAL: 
	22. TITLE: Associate Regional Administrator

23. REMARKS:

Revision: HCFA-PM-91-6 (MB)
September 1991

Page 11a

State: Rhode Island

Citation

1902(a)(55) 2.1(d) The Medicaid agency has procedures to take applications, assist applicants, and perform initial processing of applications from those low income pregnant women, infants, and children under age 19, described in Section 1902(a)(10)(A)(I)(IV), a(10)(A)(I)(VI), and (a)(10)(A)(ii)(IX) at locations other than those used by the title IV-A program including FQHCs and disproportionate share hospitals. Such application forms do not include the AFDC form except as permitted by HCFA instructions.

TN.No.: 01-007

Supersedes

Effective Date: 01/1/01 or as
effective by law

Approval Date: 4-4-01

TN No.: new

HCFA ID 7985E